

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-7

02944

CERTIFICATE OF DEATH

Reg. Dist. No. 168

1. PLACE OF DEATH:

County GarrettCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Phillip Baker

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 27, 1863

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8223

hrs.

min.

9. Birthplace

Shade Mill, Garrett Cty., Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

John Baker

13. Birthplace

Germany

MOTHER

14. Maiden name

Katherine Arnold

15. Birthplace

Pennsylvania

16. Informant

Mrs. Francis Weinbauer

Address

Frostburg, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof March 26, 1945
(month) (day) (year)

Cemetery or crematory

Johnson Cemetery

Location

Frostburg, Md.

16. Funeral director

J. J. Dubit

Address

Frostburg, Md.

19.

(Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Garrett

City or town

Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 23

19

45 at 11:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1

19

44 toMarch 23 1945

and that I last saw him alive on

3-231945

Immediate cause of death

Chronic myocarditis

DURATION

5 yrs.

Due to

arterio sclerosis

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. C. Nichol, M.D.

M. D. or other

Address

Frostburg, Md.Date signed 3/24/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(159)

02945

166

Reg. Dist. No.

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Md. Route
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland, Md. Route.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Louise

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 30th, 19458. AGE: Years Months Days If less than one day
0 0 0 3 hrs. min.9. Birthplace Garrett County, Maryland.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Clarence Broadwater.13. Birthplace Garrett County, Maryland.14. Maiden name Hazel Bowman.15. Birthplace Garrett County, Maryland.16. Informant Clarence Broadwater.Address Oakland Md. Route.17. Burial Date thereof March 31st, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Thayerville Cemetery.Location Thayerville, Maryland.18. Funeral director Emroy D. Bolden.Address Oakland, Maryland.19. 3/31/ 19 45 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 45 at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on
March 30 19 45 to 19 45and that I last saw her alive on March 30 19 45Immediate cause of death Thrombocytopenia
(between 6 & 7 months)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold C. Miller Md.Address Egle N. W. Va. Date signed 4/4/45

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BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02946

Reg. Dist. No. 164

1. PLACE OF DEATH: County <u>Garrett</u> City or town <u>Rural-- Accident, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Lifetime</u> Hospital, institution, or street address where death occurred: <u>Home</u> How long in hospital or institution? <u>2 or 3 weeks at onset of illness</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Garrett</u> City or town <u>Rural-- Accident, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Near Accident, Maryland</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>no</u>			
3. (a) FULL NAME <u>Anna Bushman</u>				3. (b) Social Security Number <u>0</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>George Bushman</u> 6. (c) If alive, give age <u>61</u> years				20. DATE OF DEATH <u>March 10</u> , 19 <u>45</u> , at <u>4:30 p.m.</u>			
7. Birth date of deceased (mo., day, yr.) <u>February 28- 1883</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Feb. 23</u> , 19 <u>40</u> , to <u>Mar. 10</u> , 19 <u>45</u> , and that I last saw her alive on <u>Feb. 2</u> , 19 <u>45</u> .			
8. AGE: Years <u>62</u> Months <u>-</u> Days <u>10</u> If less than one day <u>-</u> hrs. <u>-</u> min.		9. Birthplace <u>Rural Near Accident Md</u> (Town, county, and state)		Immediate cause of death <u>Cerebral Hemorrhage</u>		DURATION <u>4 mo.</u>	
10. Usual occupation <u>House Work</u>				Due to <u>Arteriosclerosis</u>		<u>?</u>	
11. Industry or business				Due to			
12. Name <u>Adam Snider</u>		13. Birthplace <u>Rural Near Accident Md</u>		Other conditions <u>Arthritis, hypertension, myocarditis</u> (Include pregnancy within 8 months of death)			
14. Maiden name <u>Elizabeth Miller</u>		15. Birthplace <u>Rural Near Accident Md</u>		Major findings of operations			
16. Informant <u>George Bushman</u> Address <u>Accident Md</u>				Autopsy results		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u>		Date thereof <u>3-13-1945</u> (month) (day) (year)		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>-</u> Date of <u>-</u>			
Cemetery or crematory <u>German Luthern</u>		Location <u>Accident Md</u>		Where did injury occur? (City or town) (County) (State)			
18. Funeral director <u>Allen W. Whiteley</u> Address <u>Grantsville Md</u>				Injured at home, farm, industry, public place (where?)			
19. Mar. 12 19 <u>45</u> <u>Emma D. Sporelein</u> (Date rec'd by registrar) Registrar				Means of injury <u>St. J. Slower M.T.S.</u>		Injured at work?	
23. SIGNATURE <u>St. J. Slower M.T.S.</u> Address <u>Friendsville, Md.</u> Date signed <u>3-12-45</u>							

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-8

CERTIFICATE OF DEATH

Reg. Diat. No. 161

1. PLACE OF DEATH:

County Garrett
 City or town Friendsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home
 How long in hospital or institution? Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Rural-Friendsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near-Friendsville, Maryland
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dale William Friend

3. (b) Social Security Number

04. Sex Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife none

7. Birth date of

deceased (mo., day, yr.)

March 15, 1945

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

2 days

hrs.

min.

9. Birthplace

Near Friendsville, Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

Reed Friend

13. Birthplace

Friendsville, Maryland

MOTHER

14. Maiden name

Mildred Thomas

15. Birthplace

Friendsville, Maryland

16. Informant

Mrs. Bliss Friend

Address

Friendsville, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 17, 45

(month) (day) (year)

Cemetery or crematory

Bloomington

Location

Near Friendsville

18. Funeral director

H. H. Dumas

Address

Friendsville, Maryland

19.

Mar. 17, 45

(Date rec'd by registrar)

45John C. Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 171945to March 171945and that I last saw him alive on March 17, 1945

Immediate cause of death

Congenital malformation of stomach and heart

DURATION

life

Due to

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

H. X. Oliver, M.D.

M. D. or other

Address

Friendsville, Maryland

Date signed

3-17-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REPORTED TO (NAME OF PHYSICIAN) AT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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APR 4 1945
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 37

CERTIFICATE OF DEATH

Reg. Dist. No. 02948/66

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Edwin Ephrian Friend.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Carrie Pope Friend
Deceased 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 4th, 1867
 8. AGE: Years 77 Months 11 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Garrett County, Maryland.
 (Town, county, and state)
 10. Usual occupation Retired Clerk

11. Industry or business

12. Name Henry E. Friend.
 13. Birthplace Garrett County, Maryland.
 14. Maiden name Sarah Elizabeth Blackburn.
 15. Birthplace Mineral County, West Va.

16. Informant Mr. W. W. Dawson.
 Address Oakland, Maryland.

17. Burial Date thereof March 28/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oakland Cemetery.
 Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.
 Address Oakland, Maryland.

19. 3/27/45 Julia Rowan
 (Date rec'd by registrar) (Month) (Day) (Year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Monday 26 1945 at 4:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944 to Mar 26 1945
 and that I last saw him alive on March 26 1945

Immediate cause of death Cerebral thrombosis DURATION 6 days

Due to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edw. D. Bolden M. D. or other _____

Address Oakland, Md. Date signed 3/27/45

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STATE OF TEXAS

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APR 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 67

CERTIFICATE OF DEATH

Reg. Dist. No. 02949 166

1. PLACE OF DEATH:

County Garrett
 City or town Swanton, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Swanton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Estella Rose Friend.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Joseph F. Friend.
Deceased 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 4th, 1874
 8. AGE: Years 71 Months 1 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Garrett County, Md.
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business _____
 12. Name Joseph R. Glass.
 13. Birthplace Accident, Md.
 14. Maiden name Caroline Sweitzer.
 15. Birthplace Garrett County, Maryland

16. Informant Mrs. Pearl Thrasher.
 Address Deer Park, Maryland.
Burial Date thereof April 1st/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory George Cemetery.
 Location Near Swanton, Md.

18. Funeral director Emroy D. Bolden.
 Address Oakland, Maryland.
 19. 3/3/ 19. 45 Julia Raven
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30-45 19. _____ at _____ M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-40 19. _____ to 3-30-45 19. _____
 and that I last saw him/her alive on 3-29-45 19. _____
 Immediate cause of death Hypostatis Congestion of lungs
 DURATION 2 days
 Due to _____
 Due to _____
 Dilated Heart
 Other conditions Diabetes 3 weeks
 (Include pregnancy within 3 months of death) 5 yrs

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Edward E. ... M. D. or other _____
 Address Oakland, Maryland Date signed 3-30-45

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APR 10 1945
BUREAU V.E.

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RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 0295966

1. PLACE OF DEATH:

County Garrett
 City or town Oakland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John S. Guegy.

3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed or divorced Married6.(b) Name of husband or wife Mrs. Mary Guegy6.(c) If alive, give age 80 years7. Birth date of deceased (mo., day, yr.) Aug. 5, 1860

8. AGE: Years 84 Months 6 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Guegy Church, Garrett Co.
(Town, county, and state)10. Usual occupation Retired School Teacher

11. Industry or business

12. Name Samuel Guegy.13. Birthplace Meyersdale Pa.14. Maiden name Elizabeth Shlabach.15. Birthplace Somerset County, Pa.16. Informant Mrs. Mary GuegyAddress Oakland Md.17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof March 4, 1945
(month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland Md.18. Funeral director Emory W. BoldenAddress Oakland Md.19. 3/2/45 19 45 Julia Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 45 at 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 43 to Mar 19 45
 and that I last saw him alive on Feb 20 19 45

Immediate cause of death Chronic Arteriosclerosis
 DURATION

Due to _____

Due to _____

Due to _____

Due to _____

Other conditions Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. J. Kammeyer M. D. or other _____Address Oakland Md. Date signed 3/2/45

U. S. DEPARTMENT OF HEALTH

U. S. BUREAU OF HEALTH

U. S. BUREAU OF HEALTH

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APR 10 1945

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

02951

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Julia A. Harsch

3. (b) Social Security Number

- 0 -4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Matthew Harsch6. (c) If alive, give age _____ years
deceased7. Birth date of deceased (mo., day, yr.) April 1 - 18618. AGE: Years 83 Months 11 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Garrett County,
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Attorney Shaffer13. Birthplace Germany14. Maiden name Sophronia Garrow15. Birthplace Germany16. Informant Miss Mary HarschAddress Oakland, Md.17. Burial St Peter's Cemetery
(Burial, cremation, or removal. Which?) Date thereof March 9 / 45
(month) (day) (year)Cemetery or crematory Oakland, Md.Location Oakland, Md.18. Funeral director Emory D. BoldenAddress Oakland, Md.19. 3-8-45 Julia Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1945, at 4:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945, to March 6 1945and that I last saw him alive on March 6 1945Immediate cause of death Cerebral thrombosisDue to Arteriosclerosis

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

DURATION

6 days

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. J. Bampton M.D.Address Oakland, Md. Date signed 3/8/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

HEIGHT

WEIGHT

TEMPERATURE

POSTMORTEM EXAMINATION

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0295266

1. PLACE OF DEATH:

County Garrett
 City or town Rural Deer Park
 (If outside city or town limits, write RURAL and give nearest town)
20 yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Rural Deer Park
 (If outside city or town limits, write RURAL and give nearest town)
12 M. S. W. Deer Park
 Street No. -----
 (If rural, give LOCATION)

 2.(a) If veteran, name war -----

3. (a) FULL NAME

Mayme Wright Landis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Elvin Landis
 6. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) Nov. 28, 1887
 8. AGE: Years 57 Months 3 Days 3 If less than one day
 ----- hrs. ----- min.

9. Birthplace Austen; Preston Co., W. Va.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business Own Home

FATHER 12. Name George W. Wright
 13. Birthplace England

MOTHER 14. Maiden name Mannah Mitter
 15. Birthplace Preston Co., W. Va.

16. Informant Elvin Landis
 Address Deer Park, Md.

17. Burial March 6, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory King Cemetery
 Location 1 1/2 Mi. East Loch Lynn

18. Funeral director Herbert C. Leighton
 Address Oakland, Maryland

19. 3-5- 19 45 Julia Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1945 19 3:45P/ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-28-43 19 3-3-45 19

and that I last saw h. ex. alive on 2-2-45 19

Immediate cause of death Sarcoma of Breast
Breast Removed about 1 year ago
This entered vital parts involving
lungs
 Due to 3 weeks

Due to -----
 Other conditions -----

(Include pregnancy within 8 months of death)

Major findings of operations -----
 ----- Date of op. -----

Autopsy results -----
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ----- Date of -----
 Where did injury occur? -----
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----
 Means of injury ----- Injured at work? -----

23. SIGNATURE Edward E. Brown
Oakland, Maryland M. D. or other
 Address ----- Date signed 3-6-45

STATE OF TEXAS DEPARTMENT OF HEALTH

52850

DEPARTMENT OF HEALTH

RECEIVED

APR 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(31-2)

62953

CERTIFICATE OF DEATH

Reg. Dist. No. 163

1. PLACE OF DEATH:

County GarrettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County GarrettCity or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Artie Mishie Lantz

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Joseph J. Lantz7. Birth date of deceased (mo., day, yr.) Aug. 23, 19086. (c) If alive, give age 40 years

8. AGE:

Years 36Months 7Days 9

If less than one day

hrs.

min.

9. Birthplace Barnum Hill, Garrett, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Hensie Harnick13. Birthplace Garrett Co. Md.14. Maiden name Oliver Harnick15. Birthplace Garrett Co. Md.16. Informant Joseph J. LantzAddress Bloomington, Md.17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Apr 3, 1945

(month) (day) (year)

Cemetery or crematory Bloomington Cem.Location Bloomington, Md.18. Funeral director Mrs. Fay Boal BerryAddress Westernport, Md.19. Apr 3, 1945

(Date rec'd by registrar)

Lorrey Pattison
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1945 at 11:35 a.m.21. CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st to March 31, 1945and that last saw a alive on March 30, 1945Immediate cause of death Cardio Renal crisisDue to Rheumatic Fever

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Samuel C. Volante Jr.

M. D. or other

Address Garret W 4Date signed Apr 4, 1945

RECEIVED

APR 20 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

02954

161

Reg. Dist. No. _____

1. PLACE OF DEATH:

County Garrett
City or town Selbysport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: _____
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 65 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Selbysport, Md Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Frank Lowdermilk

3. (b) Social Security Number

219-03-8443

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

8 (b) Name of husband or wife Ethel Lowdermilk
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Apr 19-188

8. AGE: Years 65 Months 10 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Foyes, Md
(Town, county, and state)

10. Usual occupation Sawyer

11. Industry or business Saw mill

12. Name Frank Lowdermilk

13. Birthplace Garrett, Co. Md

14. Maiden name Sarah Riley

15. Birthplace Garrett, Co. Md

16. Informant Ethel Lowdermilk

Address Friendsville R.H. Md

17. Burial Date thereof Mar 20-1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Addison Cemetery

Location Addison Pa

18. Funeral director H.B. Risherbarger

Address Addison Pa

19. Mar 19, 1945 Ira C. Runk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 45 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 42 to March 17 19 45 and that I last saw him alive on March 17, 19 45

Immediate cause of death Coronary Thrombosis

DURATION 3wks.

Due to arteriosclerosis of coronary vessels

Due to Chronic Nephritis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. X. G. Lums M.D.

M. D. or other _____

Address Friendsville, Md. Date signed 3-17-45

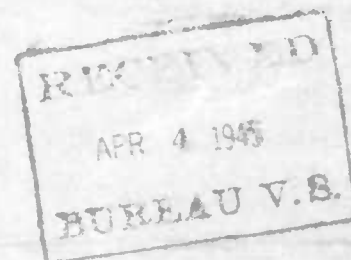
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

CERTIFICATE OF DEATH

02955

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
90 yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Loch Lynn
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Garrett
 City or town Mt. Lake Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -----
 (If rural, give LOCATION)
 2.(a) If veteran, name war -----

3. (a) FULL NAME

Richard Ream

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Catherine Elizabeth Ream

7. Birth date of deceased (mo., day, yr.)

May 20, 1854

6. (c) If alive, give age ----- years

8. AGE:

Years

Months

Days

If less than one day

90105

hrs.

min.

9. Birthplace Garrett Co., Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Own Farm

FATHER

12. Name Ell Ream

13. Birthplace

Unknown

MOTHER

14. Maiden name

Mary Wilson

15. Birthplace

Unknown

16. Informant

J. W. Ream

Address

Mt. Lake Park, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

March 28, 1945

(month) (day) (year)

Cemetery or crematory

Oakland Cemetery

Location

Oakland, Md.

18. Funeral director

Herbert C. Leighton

Address

Oakland, Md.

19.

(Date rec'd by registrar)

19 453-27-45Julius RowanLoch Lynn

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945 19 45 at 12:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 16 19 42 to March 25 19 45
 and that I last saw March 23 alive on 19 45

Immediate cause of death

Smallpox, rt. foot

DURATION

Due to

Due to

Other conditions

Amputation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. J. Bannister M.D.

M. D. or other

Address

Oakland, Md.

Date signed

3/27/45

RECEIVED

APR 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02956

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 53 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Oakland,
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Mary Kennedy Sincell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.6. (b) Name of husband or wife Harry C. Sincell6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) October 2d, 1864.8. AGE: Years 81 Months 5 Days 19 If less than one day _____ hrs. _____ min.9. Birthplace Charlestown, W. Va.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name J ohn W. Kennedy.13. Birthplace Charlestown, W. Va.14. Maiden name Sarah Rutheford.15. Birthplace Charlestown, W. Va.16. Informant Mr. Harry C. Sincell.Address Oakland, Maryland.17. Burial Date thereof March 23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland Cemetery.Location Oakland, Maryland.18. Funeral director Emroy D. Bolden.Address Oakland, Maryland.19. 3-22- 19 45 John Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 19 45 at 9:05 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A. M.Tues. 19 43 to 3/21 19 45and that I last saw her alive on March 20 19 45Immediate cause of death Acute uremia DURATION 2 daysDue to Uteral obstruction 3 daysDue to Carcinoma Uterine Cervix 5 yrswith metastases

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harold C. Miller, M.D. M. D. or otherEglen W. Va. Date signed 3/22/45

RECEIVED

RECEIVED

RECEIVED

APR 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Crellin, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clyde Rodney Smith.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married.6. (b) Name of husband or wife Mrs. Grace Smith7. Birth date of 6. (c) If alive, give age 63 yearsdeceased (mo., day, yr.) October 27 18838. AGE: Years Months Days If less than one day
62 4 19 hrs. min.9. Birthplace Dushore, Pennsylvania.
(Town, county, and state)10. Usual occupation Farmer.

11. Industry or business

FATHER 12. Name Stephen A. Smith.13. Birthplace New York, N. Y.MOTHER 14. Maiden name Eleanor J. Wandell.15. Birthplace Pennsylvania.16. Informant Mrs. Clyde Smith.Address Crellin, Md.17. Burial Date thereof March 18/45.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Terra Alta Cemetery.Location Terra Alta, W. Va.18. Funeral director Emroy D. Bolden.Address Oakland, Maryland.19. 3-17. 45 Julius Rowan
(Date rec'd by registrar) 19. June Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County Garrett
City or town Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

213-05-4806

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 19 45, at 4:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A. M.Mar 7 19 45 to Mar 16 19 45and that I last saw him alive on Mar 15 19 45Immediate cause of death Heart failure

DURATION

Due to Ventricular Fibrillation 1 dayDue to Coronary Fibrillation 3 wksOther conditions Proximal Atherosclerosis 6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Julius Rowan M. D. or otherAddress Terra Alta Ark Date signed 3/16/45

CERTIFICATE OF DEATH

NO. 100-100000

RECEIVED
APR 10 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 739

CERTIFICATE OF DEATH

02958

Reg. Dist. No. 172

1. PLACE OF DEATH:

County Garrett
 City or town Shallmar
 (If outside city or town limits, write RURAL and give nearest town) 7 mon.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Shallmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Jane Tasker

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife William Washington Tasker
 7. Birth date of deceased (mo., day, yr.) January 2, 1866 6. (c) If alive, give age _____ years
 8. AGE: Years 79 Months 2 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Chaffee, Garrett Co., Md.
 (Town, county, and state)
 10. Usual occupation Housework
Own Home
 11. Industry or business
 12. Name Joseph Tasker
 13. Birthplace Ma.
 14. Maiden name Katherine Sharpless
 15. Birthplace Mineral Co., W. Va.

16. Informant Mrs. Dolly Conn
 Address Shallmar, Md.
 17. Burial
 (Burial, cremation, or removal. Which?) Date thereof MARCH 29-45
 (month) (day) (year)
 Cemetery or crematory Hamill Cemetery
Kitzmiller, Md.
 Location
 18. Funeral director Otha F. Sharpless
 Address Blaine, W. Va.

19. MAR 30 19 45 AWBAM
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 45 at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1943 to March 29, 1945
 and that I last saw him alive on March 29, 1945

Immediate cause of death Acute Myocarditis
 DURATION 1 week

Due to Arrhythmia Fibrillation 2 yrs.

Due to Hypertension 2 yrs.

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Antopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Ralph Colandella M.D.
Kitzmiller, Md. M. D. or other
 Address _____ Date signed March 30-45

APR 23 1945
BUREAU V.N.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM NO. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Dist. No. 02959 66

1. PLACE OF DEATH:

County Garrett

City or town Sang Run, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Sang Run, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near-Sang Run Maryland

(If rural, give LOCATION)

2(a) If veteran, name war no

3. (a) FULL NAME

Samuel Jackson Thomas.

3. (b) Social Security Number

0

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife Ora Bell Thomas.

6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) April 11th 1869

8. AGE: Years Months Days If less than one day

75

76

11

6

hrs. min.

9. Birthplace Friendsville, Maryland.

(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

12. Name Abraham Thomas.

13. Birthplace Friendsville, Md.

14. Maiden name Sarah Teets.

15. Birthplace West Va.

16. Informant Jackson Thomas.

Address Oakland, Md.

17. Burial Date thereof March 20/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Sang Run Cemetery.

Location Sang Run, Maryland.

18. Funeral director Emroy D. Bolden.

Address Oakland, Md.

19. 3-20-45 Julia Rowan

(Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th, 1945, at 10:45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from P. M. Feb. 26 1945 to March 17, 1945

and that I last saw him alive on March 3 1945

Immediate cause of death Congestive heart Failure

DURATION

?

Due to Arteriosclerosis

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Glover, M.D.

M. D. or other

Address Friendsville, Maryland Date signed 3-20-45

CERTIFICATE OF DEATH

BUREAU V.B.

APR 10 1905

K. ROBERT V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1942)

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:

County GarretteCity or town Friendsville, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Rural -Friendsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. near Sands Springs, Md.
(If rural, give LOCATION)2.(a) if veteran, name war no

3. (a) FULL NAME

Charles W Van Sickie

3. (b) Social Security Number

0

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Sarah VanSickle

7. Birth date of deceased (mo., day, yr.)

6.(c) if alive, give age 72 years

8. AGE:

Years

Months

Days

If less than one day

7286

hrs. min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Own Farm

FATHER

12. Name

Calvin VanSickle

13. Birthplace

Not Known

MOTHER

14. Maiden name

Nancy Fike

15. Birthplace

Maryland

16. Informant

Address

Brandonville, W.Va.

17.

(Burial, cremation, or removal. Which?)

Date thereof

3-9-45
(month) (day) (year)

Cemetery or crematory

Umbel Cem-

Location

18. Funeral director

Address

Brandonville, W.Va.

19.

3-8-45

(Date rec'd by registrar)

19.

451945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1945 19 7:30p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 19 to Mar. 7, 1945and that I last saw him alive on Feb. 24 19 45

Immediate cause of death

Congestive Heart Failure

DURATION

2 wks.Due to Arteriosclerosis?

Due to

Other conditions Chronic Nephritis and Arthritis?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

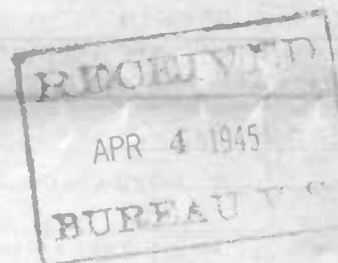
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Friendsville, Maryland Date signed 3-8-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

02961

Reg. Dist. No. 172

1. PLACE OF DEATH:

County Garrett
 City or town Rural - Kitzmiller
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40yr
 Hospital, institution, or street address where death occurred:
Peerless
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Rural - Kitzmiller
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Peerless
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Abraham Wilson

3. (b) Social Security Number

214-03-4603

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Minnie Lucretia (Paugh) Wilson 8.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1877

8. AGE: Years 67 Months 3 Days 29 If less than one day
hrs.min.

9. Birthplace Rural - Kitzmiller, Md.
 (Town, county, and state)
Farmer & Coal Miner

10. Usual occupation

11. Industry or business

12. Name Robert Charles Wilson13. Birthplace Kitzmiller, Md.14. Maiden name Elizabeth Webb15. Birthplace Baltimore, Md.16. Informant Mrs. John A. Wilson

Address Kitzmiller, Md.

17. Burial Date thereof March 15, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory I.O.O.F. CemeteryLocation Elk Garden, W.Va.18. Funeral director Otha E. SharplessAddress Blaine, W.Va.

Address

19. 3-12 3/4 1945 C. W. Barrow
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 45 10 A.
 19....., at.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1943 to March 15 1945
 and that I last saw him alive on March 10 1945

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Chronic Atrial Fibrillation

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ralph Culandrella M.D.
 Address Kitzmiller, Md. Date signed March 15-45

CERTIFICATE OF DEATH

RECEIVED

MAY 4 1945

BUREAU V.B.